ALL THERAPY
Physical Therapy & Wellness

212 Carter Drive, Suite C
Middletown, DE 19709
(302) 376-5578 (b) * (302) 376-5580 (f)
www.ALLTherapy.net

Movement is freedom

OFFICE USE ONLY:
Initial Date of Contact: ___/___/2015
Patient IE Date: ___/___/2015
Date Insurance Verified: ___/___/2015

PATIENT INFORMATION FORM

PATIENT DEMOGRAPHICS

PATIENT'S NAME: _____

ADDRESS: _____

CITY: _____ ST_____ ZIP_____

HOME TEL NUMBER:_____

CELL #:_____ WK#:_____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____/_____/_____

EMPLOYER:_____

SEX: M = MALE F= FEMALE (CIRCLE ONE)

STATUS (CIRCLE ONE):

SINGLE/ MARRIED/ DIVORCED/ WIDOWED /CHILD

EMAIL:_____

EMERGENCY CONTACT:

NAME:_____

RELATIONSHIP:_____ TEL#:_____

PRIMARY MEDICAL INSURANCE:

(PLEASE COMPLETE ALL FIELDS)

INSURANCE:_____

POLICYHOLDER'S NAME: _____

POLICYHOLDER'S DOB: _____ SS#: _____

EMPLOYER: _____

MEMBER ID #: _____

GROUP #: _____

INSURANCE CONTACT #: _____

MEDICAL RELEASE/AUTHORIZATION OF PAYMENT:

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I FURTHER AUTHORIZE PAYMENT TO BE MADE DIRECTLY ALL THERAPY FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO ALL THERAPY FOR ALL CHARGES NOT COVERED.

_____ _____
PATIENT SIGNATURE/RESPONSIBLE PARTY DATE

HOW DID YOU HEAR ABOUT US? _____

INJURY/ONSET:(CIRCLE ONE)

IS INJURY RELATED TO AUTO? ____YES (SEE NEXT QUESTION) ____NO

(IF YES-WHAT STATE DID ACCIDENT TAKE PLACE?) _____

IS INJURY RELATED TO WORK? ____YES ____NO

DATE OF INJURY/ONSET: _____

CAUSE OF INJURY: _____

INJURY BODY PART: _____

DATE OF SURGERY: _____/_____/_____

HAVE YOU HAD PRIOR PHYSICAL THERAPY? ___ YES ___NO

WHEN? _____ BODY PART: _____

PRIMARY/REFERING PHYSICIAN INFO:

(IF YOU HAVE AN ASSIGNED PC PHYSICIAN BY INS CO.-ENTER THIS INFO):

NAME:_____

TEL #:_____

NPI#:_____ UPIN#:_____

(NPI & UPIN TO BE COMPLETED BY OFFICE STAFF)

SECONDARY INSURANCE INFORMATION:

(PLEASE COMPLETE ALL FIELDS)

INSURANCE: _____

POLICYHOLDER'S NAME: _____

POLICYHOLDER'S DOB: ____/_____/_____ SSN#: _____

EMPLOYER: _____

MEMBER ID#: _____

GROUP NUMBER: _____

INSURANCE CONTACT #: _____

WORKER'S COMPENSATION/AUTO-PIP INSURANCE: (CIRCLE ONE) (MUST BE YOUR AUTO INS-NOT THIRD PARTY)

INSURANCE: _____

CLAIM #: _____

DATE OF ACCIDENT: _____

ADJUSTER'S NAME: _____

ADJUSTER'S PHONE #: _____

ADDRESS TO SUBMIT CLAIMS: _____

_____

CITY: _____ ST: _____ZIP:_____

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ATTORNEY INFORMATION:

ATTORNEY' NAME: _____

PHONE #: _____

FAX #: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____